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Medicaid Update

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Update on Medicaid Fee-for-Service Prior Authorization of Topical Compounded Drug Products

Medicaid Fee-for-Service (FFS) will implement editing on prescriptions for topical compounded drug products effective November 29, 2018. These edits will ensure that compounded topical drug products meet State and Federal regulations and that the compound ingredients are Federal Drug Administration (FDA) or compendia-supported for topical use.

Change in process for Topical Compound Prior Authorization (PA):

- This type of PA will require that the actual PA number be obtained via the Magellan call center and then provided to the pharmacy. **This is a change from the current process.**
- The pharmacy will then have to input the PA number on the pharmacy claim transaction for a topical compound prescription to adjudicate and approve. **This is a change from the current process.**

Two new eMedNY edits for Topical Compound:

- **Edit 02282** – NCPDP code 75, PA Required – Call Magellan. This is specific to compounds.
- **Edit 02283** – NCPDP code E2, Missing Invalid (M/I) Route of Administration. NCPDP field 995-E2 (Route of Administration) will be required for any compound claim.

Please note that Prior Authorization (PA) requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

The following is a link to the most up-to-date information on the Medicaid FFS Pharmacy PA programs. This document contains a full listing of drugs subject to the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), Drug Utilization Review (DUR) Program, Brand Less than Generic Program (BLTG), Dose Optimization Program and the Mandatory Generic Drug Program (MGDP): https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

To obtain a PA, please call the prior authorization clinical call center at 1-877-309-9493. The clinical call center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain a PA.

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In This Issue…

Patient-Centered Medical Home and Advanced Primary Care Incentive Payment Programs: Comprehensive Payment Policy and Billing Guidance

The following article provides comprehensive policy and billing guidance pertaining to the Statewide Patient-Centered Medical Home (PCMH) and Advanced Primary Care (APC) incentive payment programs.

Overview

New York State (NYS) supports initiatives that improve primary care through the medical home model which promotes the Triple Aim goals of improved health, better health care and consumer experience, and lower cost. These initiatives include the National Committee for Quality Assurance's (NCQA) PCMH programs, and the APC program. Providers that achieve PCMH or APC recognition are eligible to receive Medicaid or Child Health Plus (CHP) incentive payments. Payments are provided in the form of either per member per month (PMPM) capitation payments for Medicaid Managed Care (MMC) and CHP members, or as a per-visit "add-on" payment for eligible claims billed for services provided to Medicaid Fee-For-Service (FFS) members.

New York Medicaid or CHP providers receiving incentive payments through the Adirondack Medical Home Demonstration Project are not eligible for incentive payments through either the PCMH or APC programs.

Please see the additional articles included in this edition of the *Medicaid Update* dedicated to the APC and NYS PCMH incentive payment programs titled ***Advanced Primary Care Incentive Payment Program*** and ***New York State Announces Release of State Patient-Centered Medical Home Model,*** respectively.

Lines of Business Eligible to Receive Incentive Payments

Providers with members in the following lines of business are eligible to receive Medicaid PCMH or APC incentive payments: Medicaid FFS, Mainstream MMC, CHP, HIV Special Needs Plans (HIV SNP), and Health and Recovery Plans (HARP). Incentive payments are **not** applicable to services provided to Medicare-Medicaid members (duals), members with third-party health insurance (TPHI), or members with the following coverage: Essential Plans (EP), Qualified Health Plans, Managed Long-Term Care (MLTC), and Programs of All-Inclusive Care for the Elderly (PACE).

Policy Updates

The following program updates have been implemented since the April 2018 *Medicaid Update*:

- Medicaid and CHP incentive payments will be made to providers recognized as APC.
- MMC incentive payments to CHP providers for APC Gate 2 recognition are only applicable for dates of service on or after September 1, 2018.
- For FFS Article 28 clinics, a claims processing system update is being implemented to require that the National Provider Identifiers (NPI) of the clinic and the attending primary care provider reported on the claim are **both** on the PCMH/APC Recognized Provider List. This update is to ensure that PCMH or APC incentive payments are only made for primary care or preventive medicine services rendered in a clinic setting. Please see Section 8 for additional information regarding the PCMH/APC Recognized Provider List.

Incentive Payment Rates

The table below provides a breakdown of the MMC per member per month (PMPM) and FFS incentive payment rates for practices or clinics that are recognized under APC (Gate 2), NCQA PCMH 2014 (Level 3), NCQA PCMH 2017, or *NYS PCMH* standards.

PCMH & APC Incentive Payment Programs MMC-PMPM and FFS Add-on Amounts Paid Out to Providers Effective July 1, 2018				
Incentive	***APC* Gate 2**	***2014 - Level 3* NCQA PCMH Standards**	***2017* NCQA PCMH Standards**	***NYS PCMH* Standards**
PMPM add-on for Mainstream MMC, HIV SNP, and HARP Providers	$6.00	$6.00	$6.00	$6.00
PMPM add-on for CHP Providers	$6.00 (Effective September 1, 2018)	$6.00	$6.00	$6.00
FFS Incentive add-on for Professional Claims	$29.00	$29.00	$29.00	$29.00
FFS Incentive add-on for Institutional Claims	$25.25	$25.25	$25.25	$25.25

FFS General Incentive Payment Guidance

Medicaid FFS providers will be paid add-on incentive payments effective the month the provider achieves their PCMH or APC recognition.

FFS Billing Guidance for PCMH and APC Recognized Providers

Incentive payments are only payable to those providers that are recognized as an APC Gate 2 provider or recognized under one of the following NCQA PCMH recognition programs: PCMH 2014 (Level 3); PCMH 2017; or *NYS PCMH*.

Incentive payments are only payable for primary care or preventive medicine services rendered by physicians, physician assistants and registered nurse practitioners that are included on the PCMH/APC Recognized Provider List.

Incentive payments are only available for:

- Services rendered to Medicaid-only recipients;
- Primary care or preventive medicine services (i.e., non-specialty care services);
- Specific Evaluation and Management (E&M) codes (see below);
- Specific Preventive Medicine codes; and
- Specific institutional rate codes (when applicable).

A. **FFS Billing Guidance for Office-based Practitioners providing primary care services:**
Office-based practitioners will receive a per visit add-on incentive payment when they meet the following criteria:

1. In an individual provider's practice, the individual practitioner's NPI must be included on the claim, and the practitioner must be included on the PCMH/APC Recognized Provider List as either an APC Gate 2 provider or be recognized under one (1) of the following NCQA PCMH recognition programs:
    - PCMH 2014 Level 3;
    - PCMH 2017; or
    - *NYS PCMH*.
2. In a group practice, the group practice NPI and the NPI of the rendering provider **must both** be included on the PCMH/APC Recognized Provider List as either an APC Gate 2 provider, or be recognized under one (1) of the following NCQA PCMH recognition programs:
    - PCMH 2014 Level 3;
    - PCMH 2017; or
    - *NYS PCMH*.

3. The claim must contain, and the services provided must be consistent with, one of the following E&M codes: 99201-99205, 99211-99215; or one of the following Preventive Medicine codes: 99381-99386, 99391-99396.
4. The Place of Service (POS) code on the claim must be office (POS "11").
5. The claim must include the 9-digit ZIP code of the recognized provider's **site-specific physical location**, as reported to NCQA or the APC Technical Assistance (TA) advisor that assisted them in achieving their APC practice transformation.

B. FFS Billing Guidance for Article 28 Clinics – Hospital Outpatient Departments, Diagnostic and Treatment Centers (D&TC), and Federally Qualified Health Centers (FQHC) providing primary care services:

Article 28 clinics will receive the per visit add-on incentive payment amount when they meet the following criteria:

1. In an Article 28 clinic, the clinic NPI and the NPI of the attending provider **must both** be included on the PCMH/APC Recognized Provider List as either an APC Gate 2 provider, or be recognized under one (1) of the following NCQA PCMH recognition programs:
    - PCMH 2014 Level 3;
    - PCMH 2017; or
    - *NYS PCMH*.
2. The claim must contain, and the services provided must be consistent with, one of the following E&M codes: 99201-99205, 99211-99215; or one of the following Preventive Medicine codes: 99381-99386, 99391-99396.
3. The submitted rate code must be one of the following: 1400, 1407, 1422, 1425, 1432, 1435, 1444, 1447, 1450, 1453, 2887, 2888, 2889, 2940-2942, 2945, 2985, 2987, 4012, 4013.
4. The claim must include the 9-digit ZIP code of the recognized clinic's **site-specific physical location**, as reported to NCQA or the APC TA advisor that assisted them in achieving their APC practice transformation.

Medicaid Managed Care (MMC) Incentive Payment Guidance

Incentive payments are made directly to the provider by the MMC plan(s) with which the provider contracts. The incentive payments are made as a PMPM capitation payment. MMC plans are required to pay PMPM incentives to recognized providers for the entire period of their recognition, starting from the month of initial recognition. Regardless of the recognition effective date, payments to providers must include the entire first month of their recognition and should not be prorated. MMC plans are required to distribute incentive payments at least bi-annually; however, they are encouraged to process incentive payments on a more frequent payment schedule, if possible.

Each MMC plan determines the frequency/schedule of incentive payments. All questions regarding MMC incentive payment distribution schedules, retroactive payments, and provider recognition data should be directed to the individual MMC plan(s) with which the provider contracts. A MMC directory by plan can be found on the Department's website at: https://www.health.ny.gov/health_care/managed_care/plans/docs/mcp_dir_by_plan.pdf.

PCMH/APC Recognized Provider List

PCMH and APC-recognized providers will be included on the PCMH/APC Recognized Provider List, which is updated monthly and is the basis for payment of the FFS claim add-on and MMC and CHP PMPM incentive payments. Providers must ensure the following information is accurately reported to NCQA or the APC TA advisor that assisted them in achieving their APC practice transformation in order to receive Medicaid and CHP incentive payments:

- Providers must ensure that NCQA or their APC TA advisor has the accurate 4-digit extension of the ZIP code (ZIP+4) associated with the **site-specific physical location** for each practice site recognized as PCMH or APC;

- Providers must accurately report the NPIs for all their physicians, physician assistants, and registered nurse practitioners providing primary care services. It is the responsibility of the provider to report any changes to their provider rosters to ensure that incentive payments are made appropriately.

    - PCMH-recognized providers can utilize the NCQA Recognized Clinician Directory found here: http://recognition.ncqa.org/, to verify their recognition information. They can also access and modify their "Practice Information Workbook" to add and/or remove PCMH-recognized providers at any time by utilizing NCQA´s Practice Changes: Adding and Deleting Clinicians spreadsheet found here: http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/PCMH_PCSP_PCCC%20Workbook_Clinician_Changes%203-8-17.xlsx?ver=2017-06-27-160003-847, and submitting the change request through their MY NCQA account at https://my.ncqa.org/. Once the information has been updated through NCQA, the NYS DOH will automatically be notified of the update on a monthly basis.

    - APC providers should contact their APC TA advisor to update their provider rosters when personnel changes occur. The APC TA advisor will notify the Department of any provider-reported roster changes on a monthly basis.

- Since the PCMH/APC recognition is **site specific (physical address),** the group practice or clinic will receive the incentive payments for all the primary care physicians, physician assistants, and registered nurse practitioners employed by the group practice or site that are included on the PCMH/APC Recognized Provider List. NYS Medicaid FFS claims must include the ZIP+4, and locator code of the site specific, physical location where the services were rendered.

NYS Patient-Centered Medical Home (NYS PCMH)

On April 1, 2018, the Department released the NYS Patient-Centered Medical Home (NYS PCMH) model. The NYS PCMH recognition program is built upon the NCQA PCMH model and is a primary care practice transformation model that is exclusive to NYS. Practices that are new to the NCQA program will need to complete the criteria under the NYS PCMH model. NCQA PCMH 2014 or 2017-recognized practices will need to transition to the NYS PCMH model once their current recognitions expire, if they still want to be recognized by NCQA. APC-recognized practices are also transitioning to NYS PCMH. Please see the article included in this Medicaid Update edition entitled, **New York State Department of Health Announce Release of New York State Patient-Centered Medical Home Model** and the NYS Health Innovation homepage found here: https://www.health.ny.gov/technology/innovation_plan_initiative/.

For Questions and Information Related To:

Medicaid FFS incentive payments, including but not limited to missing incentive payments, claim add-on incentive payment amounts, and/or practice/provider recognition dates.
Contact: Computer Sciences Corporation (CSC a/k/a CSRA) at 1-800-343-9000 or via email at emednycallctr@csra.com or visit https://www.emedny.org/ for additional information.

APC practice transformation, including but not limited to any questions pertaining to the date of APC recognition, or other APC practice recognition information.
Contact: The Technical Assistance (TA) advisor that assisted in achieving APC recognition.
Providers can find a list of the TA vendors on the Department's website here: https://www.health.ny.gov/technology/innovation_plan_initiative/ta_contact_info.htm.

MMC PMPM incentive payments for Mainstream MMC, and all associated MMC lines of business (HIV SNP, CHP, and HARP);
Contact: The MMC plan that is responsible for the distribution of their APC incentive payments. An MMC directory by plan can be found on the Department's website here: https://www.health.ny.gov/health_care/managed_care/plans/docs/mcp_dir_by_plan.pdf.

Providers seeking assistance with FFS Policy:
Contact: Office of Health Insurance Programs at 518-473-2160.

NYS Child Health Plus (CHP) FFS Policy:
Contact: The Bureau of Child Health Plus Enrollment at (518) 473-0566.

The Division of Health Plan Contracting and Oversight is responsible for ensuring that the applicable laws and regulations relative to the MMC contracts are adhered to. Additional information and/or questions regarding MMC contracting issues may directed to bmcfhelp@health.ny.gov.

For more information on how to achieve NCQA PCMH recognition, providers may contact NCQA at (888) 275-7585 or visit NCQA's website at www.ncqa.org.

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Physician Healthcare Common Procedure Coding System Billing Guidance

It is imperative that providers furnish accurate drug information when submitting claims for physician-administered drug (Healthcare Common Procedure Coding System [HCPCS]) claims. An analysis of such claims identified many claims with *paid amounts* of $0.01. A survey of these claims uncovered that they are being submitted in error, as these drugs have already been billed to Medicaid by pharmacies.

In the scenario above, where pharmacies are billing Medicaid for the medication, the Provider administering the drug should only bill for the procedure/administration fee with the proper administration code. Providers should not submit $0.01 as a paid amount for HCPCS reimbursement and must enter a valid amount in the "paid amount" field, including zero when appropriate.

To Ensure Accurate Claiming

The 11-digit National Drug Code (NDC) **must** correspond to the actual prescription drug being dispensed and must accurately reflect what is dispensed (including package size). Do not bill for one manufacturer's product and dispense another manufacturer's product. More information about this requirement can be found in the August 2009 *Medicaid Update*.

Note:

- Billing with incorrect NDCs may be considered fraudulent billing and subject to audit.
- NDCs are used to invoice manufacturers for rebates.

If you have any questions on the above billing requirements or wish to verify coverage of a specific NDC, please contact the eMedNY call center at (800) 343-9000 or visit: http://www.emedny.org/info/formfile.html.

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Congestion Surcharge Pricing and Reimbursement Affecting Medicaid Transportation Providers

The enacted 2018-19 State Budget (S.7509-C / A.9509-C) contains statutory provisions to reduce traffic in a "congestion zone" in the **New York City Borough of Manhattan, south of and excluding 96th Street.**

Beginning January 1, 2019, *for-hire* transportation for a single passenger that originates, terminates, or enters into the congestion zone from anywhere in the State must pay a surcharge of **$2.75 per trip**. *Pool vehicles* that transport two or more passengers with separately requested transportation will be surcharged **$0.75 per passenger**. Accordingly, this surcharge will be applied to Medicaid transportation providers conducting multi-loaded or group rides. This surcharge will be applied to Medicaid taxi / livery, green car, black car, and ridesharing / transportation network vehicles (ambulance and ambulette vehicles are exempt from the surcharge).

Registration and Fee:

Medicaid transportation providers, like other transporters subject to the surcharge, must file an application for a *Certificate of Registration* in a manner prescribed by the Commissioner of Taxation and Finance. A registration fee of $1.50 must accompany the application. However, transportation providers who will be subject to the surcharge **no more** than one time in any single calendar month are not required to register. Registration is valid for three years and then subject to renewal upon payment of the registration fee. The Certificate of Registration will indicate the transportation provider's vehicle or vehicles and is **not** assignable or transferrable to other companies.

Paying the Surcharge:

Medicaid transportation providers, like other transporters subject to the surcharge, must file a monthly return with the Commissioner of Taxation and Finance within 20 days after the end of each month that indicates the number of trips and pool passengers. The form of the return, which can be electronic, will be prescribed by the Commissioner. At the time of filing the return, transportation providers must pay the amount of all surcharges to the Commissioner. Failure to pay the surcharge when due will result in a 200 percent surcharge amount penalty. Transportation providers must **not** ask Medicaid enrollees to pay the surcharge.

Reimbursement for Fee-for-Service Transportation Providers:

Transportation providers will be reimbursed for the cost of the surcharge through the Medicaid Fee-for-Service (FFS) billing system. **Medicaid Transportation providers will use the A0170 Procedure Code for tolls with the "TU" modifier for a single trip ($2.75) and the "TK" modifier for pool trips ($0.75 per person).**

Reimbursement for Managed Long Term Care Transportation Providers:

Managed Long Term Care plans will receive a regional adjustment to the capitated rate. Transportation providers will receive payment in accordance with the terms of the contract with the Managed Long Term Care plan.

Record Keeping

Transportation providers subject to the surcharge must keep records of every trip provided or arranged and amounts paid in a form required by the Commissioner of Taxation and Finance.

Questions

FFS providers should direct questions to the Bureau of Medicaid Transportation at: medtrans@health.ny.gov. Managed Long Term Care transportation providers should direct their questions to: mltcinfo@health.ny.gov.

The **NYS Department of Taxation and Finance** is in the process of implementing the surcharge, including development of the online registration process, an online monthly return, and other guidance. You are encouraged to visit the agency's webpage at: https://www.tax.ny.gov/bus/cs/csidx.htm, and their associated guidance document at: http://www.tax.ny.gov/pdf/memos/cs/m18-1cs.pdf periodically for any new information and to review the surcharge requirements.

Reminder: Mandatory Compliance Program Certification Requirement under Title 18 of the New York Codes, Rules and Regulations (NYCRR) §521.3(b)

This is a reminder from the New York State Office of the Medicaid Inspector General (OMIG) to all required providers who are subject to the Mandatory Compliance Program Requirement under New York State (NYS) Social Services Law (SSL) Section 363-d and Title 18 of the New York Codes, Rules and Regulations (NYCRR) Section 521.3(b).

On December 3, 2018, an updated SSL Certification form and its Frequently Asked Questions (FAQ) will be available on OMIG's website. A webinar posted on OMIG's website walks through how to complete the certification and can be accessed at: https://omig.ny.gov/information/webinars.

Changes to the SSL Certification form for 2018 include:

1. For all Certification Categories, except the Enrolling Provider Certification Category – a certification must be completed utilizing the Provider Identification Number (provider ID), not Federal Employer Identification Number (FEIN).
2. For the Enrolling Provider Certification Category only - a certification must be completed utilizing the FEIN.
3. National Provider Identifier (NPI) number(s) was added as an optional field to the form.
4. Two new certification categories have been added:
    - certification after correcting insufficiencies identified in a Compliance Program Review; and,
    - certification after receiving notice of regulatory action for failing to complete the annual certification.

It is the responsibility of a required provider to have an effective compliance program that meets the requirements of SSL § 363-d and 18 NYCRR § 521.3(c).

OMIG recommends visiting its website to review compliance-related information and resources; please see: https://omig.ny.gov/compliance. The Compliance Library provides copies of current forms, publications, and other resources that are helpful in conducting a self-assessment.

OMIG's listserv subscribers will be notified when the new forms are posted. To subscribe to OMIG's listserv, please visit: https://omig.ny.gov/omig-email-list-subscriptions.

If you have any questions, please contact OMIG's Bureau of Compliance at (518) 408-0401 or compliance@omig.ny.gov.

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Reminder: Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005

This is a reminder from the New York State Office of the Medicaid Inspector General (OMIG) to all providers who are subject to the requirements under Title 42 of the United States Code Section 1396a (a)(68), [42 USC §1396a (a)(68)].

42 USC §1396a provides in relevant part that:

(a) A State plan for medical assistance must —

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall —

A. establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31, [United States Code] administrative remedies for false claims and statements established under chapter 38 of title 31, [United States Code] any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in Section 1320a-7b(f) of this title);

B. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

C. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

OMIG addresses this mandate by conducting reviews of providers' compliance with the DRA requirements, and by requiring the filing of an annual certification. On **December 3, 2018**, OMIG will make available on its website the DRA Certification Form for 2018.

Although there are no changes to the certification for 2018, the Frequently Asked Questions (FAQ) have been revised. OMIG's website includes the certification form, FAQs, and a webinar that walks through how to complete the certification.

OMIG's listserv subscribers will be notified when the new forms are posted. To subscribe to OMIG's listserv, please visit: https://omig.ny.gov/omig-email-list-subscriptions.

If you have any questions, please contact OMIG's Bureau of Compliance at (518) 408-0401 or compliance@omig.ny.gov.

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NYS Medicaid Fee-for-Service Program Pharmacists as Immunizers Fact Sheet

NYS Education Law (§6527, 6801, 6802, 6909) and regulations (8 NYCRR §63.9) permits licensed pharmacists who obtain additional certification to administer the following vaccines: zoster, pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines when administered to patients 18 years of age or older; and influenza vaccines when administered to patients 2 years of age and older.

Administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid-enrolled pharmacies is reimbursable under NYS Medicaid.

The following conditions apply:

- Only Medicaid-enrolled pharmacies that employ or contract with pharmacists certified by NYS to administer vaccines will receive reimbursement for immunization services and products. Pharmacy interns cannot administer immunizations in New York State.

- Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit: http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for additional information, including the reporting of all immunizations administered to persons less than 19 years of age to the State Department of Health using the NY State Immunization Information System (NYSIIS) or to the New York Citywide Immunization Registry.

- Pharmacies will only be able to bill for **Medicaid non-dual eligible enrollees**. Dual eligible enrollees will continue to access immunization services through Medicare.

- Medicaid Managed Care members will continue to access immunization services through their health plans. For Medicaid Managed Care Organization (MCO) billing guidance, please contact the plan.

- Reimbursement for these vaccines may be based on a patient-specific order or non-patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.

- The Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for individuals **under the age of 19** are provided to Medicaid members (both FFS and MCO) free of charge by the Vaccines for Children (VFC) program.

    - Pharmacies wishing to administer VFC-available vaccines to Medicaid members under 19 years of age may enroll in the VFC program.

    - NYS Medicaid should **never** be billed for the **cost** of any vaccine for persons under 19 years of age when it is available through the VFC Program. This applies to both FFS and MCO. **Pharmacies that bill Medicaid for the cost of vaccines when it is available through the VFC Program are subject to recovery of payment.**

    - Pharmacies that are not enrolled in the VFC program may choose to provide vaccines for members under 19 years of age at **no charge** to the member or Medicaid program, and be reimbursed an immunization fee of $17.85 by NYS Medicaid.

For more information on the VFC Program visit the following web sites:
Outside of New York City (NYC): https://www.health.ny.gov/prevention/immunization/vaccines_for_children/
NYC: https://www1.nyc.gov/site/doh/providers/nyc-med-cir/vaccines-for-children-requirements.page

Billing Instructions for FFS

Consistent with Medicaid immunization policy, pharmacies will bill the administration fee and, when applicable, acquisition cost of the vaccine using the appropriate procedure codes. Procedure codes can be found on the eMedNY website here: https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx. Please note that **NDCs are not to be used** for billing the vaccine product to Medicaid FFS. Reimbursement for the cost of the vaccine for ages 19 and above will be made at no more than the ***actual*** acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

Vaccine claims submitted via the NCPDP D.0 format:

NCPDP D.0 Claim Segment Field	Value
436-E1 (Product/Service ID Qualifier)	Value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a procedure code.
407-D7 (Product/Service ID)	Enter an applicable procedure code listed in Table 2 and/or 3. Up to 4 claim lines can be submitted with one transaction.

NCPDP D.0 Companion guide can be found here: https://www.emedny.org/HIPAA/5010/transactions/index.aspx.

Billing for immunizations for ages 19 and over

For administration of multiple vaccines on the same date to patients ages 19 and older, procedure code 90471 should be used for administration of the first vaccine and 90472 for administration of ANY other vaccines administered on that day. One line should be billed for 90472 indicating the additional number of vaccines administered (insert quantity of 1 or 2).

Billing for immunizations for ages under 19

For VFC-**eligible** vaccines, whether enrolled in the VFC Program or not, the pharmacy would submit procedure code 90460 (administration of free vaccine) for administration of first or subsequent doses; and submit the appropriate vaccine procedure code(s) with a cost of $0.00.

The following procedure codes should be billed for select influenza for age 2 and over; pneumococcal and meningococcal vaccines for age 18 and over; and zoster for age 50 and over:

Procedure Code	Procedure Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
90653	Influenza virus vaccine (IIV), preservative free, for use in individuals 65 years of age and above, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use

90672	Influenza virus vaccine, quadrivalent, live, for intranasal use in individuals 2 years of age through 49
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA, preservative free, for intramuscular use for 18 years of age and older
90674	Influenza virus vaccine; quadrivalent, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90682	Influenza virus vaccine, quadrivalent, (RIV4), derived from recombinant DNA, preservative and antibiotic free for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, with preservative, for intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years of age or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use, age 2 years of age and older
90734	Meningococcal conjugate vaccine, Serogroups A, C, Y and W-135 (trivalent), for intramuscular use, age 11 through 55
90736	Zoster (shingles) Vaccine, live, for subcutaneous injection, age 50 and older
90750	Zoster (shingles) Vaccine, age 50 and older for intramuscular use
90756	Influenza virus vaccine, quadrivalent, antibiotic free, for intramuscular use

The procedure codes below should be used for the actual administration of the vaccines listed above by a pharmacist:

Procedure Code	Procedure Description
90473	Immunization **administration** of seasonal influenza intranasal vaccine for ages 19 and above **$8.57**
90471	Immunization **administration** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **$13.23**
90472	Immunization **administration** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) **$13.23**
90460	Immunization **administration** of free vaccine through VFC Program for ages under 19 years **$17.85**

Please check the Pharmacy Provider manual at https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx, **for updates on procedure codes found in Table 2 and 3 for vaccines, under "OTC and Supply Fee Schedule".**

**Contact the eMedNY Call Center at (800) 343–9000 for questions regarding FFS billing.*
**Contact the individual managed care plan for questions regarding MCO billing.*

Additional information on influenza can be found at the NYS Department of Health's website here: http://www.health.ny.gov/diseases/communicable/influenza/. CDC vaccine and immunization information can be found at http://www.cdc.gov/vaccines/index.html.

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Update to Medicaid Fee-for-Service Pharmacy Professional Dispensing Fee

Effective November 5, 2018, based on the enacted budget and Centers for Medicare and Medicaid Services (CMS) state plan approval (https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2018-09-05_spa_18-22.pdf), the Fee-for-Service (FFS) pharmacy professional dispensing fee will be revised from $10.00 to $10.08 for covered outpatient drugs, when applicable.

Retroactive adjustments back to April 1, 2018 will be handled at a future date, which will be communicated to providers ahead of time. Such adjustments will be spread out over a period of time (to be determined) and will show on the remittance with claim level detail.

Questions regarding the above-noted change can be emailed to PPNO@health.ny.gov.

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Update to the NYS Medicaid Fee-for-Service Preferred Diabetic Supply Program

Effective December 7, 2018, the NYS Medicaid Fee-for-Service (FFS) Preferred Diabetic Supply Program (PDSP) will be expanded to include products in the following categories:

Continuous Glucose Monitors:
Preferred

- Free Style Libre (monthly supplies and meters)
- Dexcom G6 (monthly supplies and meters)

Insulin Pumps:
Preferred

- Omnipod (monthly supplies and meters)

Preferred products do not require a prior authorization when billed via the National Council for Prescription Drug Program (NCPDP) format. The product must be billed using the National Drug Code (NDC). More information on the PDSP can be found at: https://newyork.fhsc.com/providers/diabeticsupplies.asp.

To request a non-preferred product, the provider must utilize the durable medical equipment (DME) Prior Approval process, and bill via the Healthcare Common Procedure Coding System (HCPCS) codes on the DME (professional) claim type.

Billing guidance for DME/supply products can be found at: https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Billing_Guidelines.pdf.

HCPCS codes and limits can be found at: https://www.emedny.org/ProviderManuals/DME/index.aspx.

For questions on the PDSP policy, contact the Medicaid Pharmacy Program at (518) 486-3209 or via email at ppno@health.ny.gov.

For questions on non-preferred DME and supplies, call the Office of Health Insurance Programs Operations (DME) at (800) 342-3005.

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All Providers

Advanced Primary Care Incentive Payment Program

The following article is to notify Medicaid Managed Care (MMC) Plans, Child Health Plus (CHP) Plans, and providers that federal approval has been granted to provide incentive payments to clinics and practitioners recognized as Advanced Primary Care (APC) providers. The following program information only pertains to providers that have achieved enhanced medical home recognition under the APC model standards. Enrollment into the APC program ended on March 31, 2018 to allow for the State's implementation, and transition into the release of the New York State Patient-Centered Medical Home (NYS PCMH) model, an innovative model for primary care practice transformation that was created exclusively for New York State (NYS).

The APC model is a statewide integrated primary care delivery model that was implemented to expand access to high-quality primary care services in NYS. The APC recognition model is a part of a Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant. The model requires providers to achieve and maintain specific capabilities around patient care quality, access, and outcomes.

NYS Medicaid provides incentive payments to APC providers that have achieved Gate 2 recognition. APC recognized providers in Medicaid Fee-for-Service (FFS), Mainstream MMC, HIV Special Needs Plans (HIV SNP), and Health and Recovery Plans (HARP) will receive incentive payments retroactive to the date of their APC recognition and will be paid at the incentive rates equivalent to the 2014 National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level 3 rates.

NYS CHP also provides incentive payments to CHP providers that have achieved APC Gate 2 recognition, at the incentive rates equivalent to the 2014 NCQA PCMH Level 3 rates. APC incentive payments to CHP providers will only be made for dates of service on or after September 1, 2018.

The table below provides a breakdown of the MMC per member per month (PMPM) and FFS incentive payment rates for practices or clinics that are recognized under APC (Gate 2) standards for the prescribed payment periods.

Advanced Primary Care (APC) Incentive Payment Program
MMC-PMPM and FFS "Add-on" Amounts Paid out to Providers

Provider	Jan. 2017 – April 30, 2018	May 1, 2018 – June 30, 2018	Effective July 1, 2018
PMPM add-on for Mainstream MMC, HIV SNP, and HARP Providers	$7.50	$5.75	$6.00
PMPM add-on for CHP Providers	N/A	N/A	$6.00 *Effective Sept. 1, 2018*
FFS Incentive add-on for Professional Claims	$29.00	$29.00	$29.00
FFS Incentive add-on for Institutional claims	$25.25	$25.25	$25.25

Medicaid FFS claims were reprocessed through eMedNY system in September 2018 to allow providers to receive retroactive incentive payments for eligible claims that had already been processed. The results of the systematic reprocessing will be reflected in the provider's Medicaid checks, and remit statements within 30-60 days from the date of this policy publication. Providers should continue to consult their Medicaid remit statements to verify the ongoing receipt of their Medicaid incentive payments.

For MMC incentive payments, providers must contact the MMC plan(s) that they contract with for any questions pertaining to the payment of their PMPM incentive payments. Each MMC plan determines the frequency/schedule of incentive payments and is required to distribute incentive payments twice per year at minimum. All questions regarding MMC incentive payment distribution schedules, retroactive payments, and provider recognition data should be directed to the individual MMC plan(s) that the provider contracts with. An MMC directory by plan can be found on the Department's at: https://www.health.ny.gov/health_care/managed_care/plans/docs/mcp_dir_by_plan.pdf.

APC providers may contact the practice transformation Technical Assistance (TA) advisors who assisted them in achieving their APC practice transformation with any questions pertaining to the date of recognition or other practice recognition information. Providers can find a list of the TA vendors on the Department's web site at: https://www.health.ny.gov/technology/innovation_plan_initiative/ta_contact_info.htm.

Please refer to the articles included in this edition of the Medicaid Update dedicated to the APC and NYS PCMH incentive payment programs entitled *"Patient-Centered Medical Home and Advanced Primary Care Incentive Payment Programs: Comprehensive Payment Policy and Billing Guidance"* and *"New York State Department of Health is Pleased to Announce the Release of the New York State Patient-Centered Medical Home Model"* for additional information.

For Questions and Information Related to:

Medicaid FFS APC incentive payments, including but not limited to missing APC incentive payments, APC claim add-on incentive payment amounts, and/or APC recognition dates.
Contact: Computer Sciences Corporation (CSC a/k/a CSRA) at 1-800-343-9000 or via email at: emednycallctr@csra.com, or visit the eMedNY website at: https://www.emedny.org/.

MMC PMPM incentive payments for Mainstream MMC, and all associated MMC lines of business (HIV SNP, CHP, and HARP).
Contact: The MMC plan that is responsible for the distribution of their incentive payments. An MMC directory by plan can be found on the Department's website at: https://www.health.ny.gov/health_care/managed_care/plans/docs/mcp_dir_by_plan.pdf.

Providers seeking assistance with FFS Policy:
Contact: Office of Health Insurance Programs at 518-473-2160.

NYS Child Health Plus (CHP) FFS Policy:
Contact: The Bureau of Child Health Plus Enrollment at (518) 473-0566.

The Division of Health Plan Contracting and Oversight is responsible for ensuring that the applicable laws and regulations relative to the MMC contracts are adhered to. Additional information and/or questions regarding MMC contracting issues may be directed to bmcfhelp@health.ny.gov.

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Patient-Centered Medical Home Model

The New York State Department of Health (the Department) is pleased to announce the release of the New York State Patient-Centered Medical Home (NYS PCMH) model.

On April 1, 2018, the Department released the NYS PCMH model, an innovative model for primary care practice transformation. New York State collaborated with the National Committee for Quality Assurance (NCQA), creator of the patient-centered medical home (PCMH) program, to develop this exclusive transformation model for all eligible primary care providers in New York State. The NYS PCMH model is built upon the NCQA PCMH model. NYS PCMH will expand access to high-quality primary care, which is key to achieving the Triple Aim goals of improved health, better health care and consumer experience, and lower cost.

The NYS PCMH model was designed as a solution to meet the transformation needs of New York State, including verifiable progress and a transition from a focus on processes to one that centers on outcomes and performance. The complexity generated by having multiple active primary care transformation programs in the State has created an opportunity for alignment by the Department. NYS PCMH seeks to combine transformation activities under one umbrella with a uniformed approach to improving primary care across New York State.

The Department provides the following resources to assist providers in implementing NYS PCMH:

- **Recognition at no cost to practices**. The Department covers either the first year NYS PCMH Recognition fee, or the first NYS PCMH Annual Reporting fee at 100 percent through the State Innovation Model (SIM) grant funding, which expires in February 2020. Practices are responsible for paying NCQA their Annual Reporting fee each year after earning NYS PCMH Recognition. There are two discount codes that have been created and should be used at the time of enrollment in Q-PASS:
  - If the practice participated in the Department's Advanced Primary Care (APC) Program, the code is: NYAPCD
  - If the practice did not participate in the Department's APC Program, the code is: GNYDOC

- **Transformation assistance**. New York State contracted with 15 organizations that specialize in NYS PCMH transformation, and transformation assistance is available at no cost to participating practices. These entities provide step-by-step assistance in managing the transformation process and support the efforts of improving the patient experience. You can find a list of the Transformation Assistance Contractors on the Department's website here: https://www.health.ny.gov/technology/innovation_plan_initiative/ta_contact_info.htm. Transformation assistance is provided for physician-led or nurse practitioner-led practices only at this time. Practices can, but are not required to, use these organizations to assist in transformation. Practices that do not use, or are not eligible to use, these contractors are encouraged to engage patient-centered medical home Certified Content Experts (CCE) which can be found on the NCQA website here: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/getting-recognized/tools-for-transformation/ncqa-pcmh-content-expert-certification. If your practice is working with a CCE that does not work for one of the Transformation Assistance Contractors, the practice can continue to maintain their relationship with that CCE.

- **Enhanced reimbursement opportunities**. Practices that participate in NYS PCMH transformation may be eligible to receive supplemental payments through state programs such as the Medicaid PCMH Incentive Payment Program. In addition, the Department is engaged regionally with commercial payers to implement voluntary, multi-payer value-based payment arrangements.

For additional information pertaining to the NYS PCMH program, please visit the NYS PCMH website here: https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/2017_pcmh_initiative.pdf.

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NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (EHR) Incentive Program (https://www.health.ny.gov/ehr) promotes the transition to EHRs by providing financial incentives to eligible professionals and hospitals. Providers who demonstrate Meaningful Use (MU) of their EHR systems are leading the way towards Interoperability, which is the ability of healthcare providers to exchange and use patient health records electronically. The ultimate goal is to increase patient involvement, reduce costs, and improve health outcomes. Since December 2011, over **$930 million** in incentive funds has been distributed **through 35,955** payments to New York State Medicaid providers.

Since 2011, Eligible Professionals & Eligible Hospitals have received:	
Number of Payments: 35,955	**Distributed Funds**: $930,966,216

Deadlines and Reminders

- Providers who attested for Payment Year (PY) 2016 MU must be approved for payment before they can attest to PY2017 MU. These providers will receive an Automatic Attestation Deadline Extension to attest PY 2017 MU in MEIPASS, after they receive payment approval for PY 2016.
- All other providers who requested an attestation deadline extension for PY 2017 MU and have been approved by NY Medicaid, will be given the deadline of **November 30, 2018** to attest in MEIPASS.
- MEIPASS is not currently accepting attestations for Payment Year 2018. NY Medicaid will make an announcement when MEIPASS is open for Payment Year 2018 MU.
- Providers must conduct a security risk analysis (SRA) each calendar year in order to meet the Protect Patient Health Information objective of meaningful use. To learn more about the requirements, please sign up for our SRA webinar.

Webinar Schedule November/December 2018 - January 2019

Meaningful Use Modified Stage 2	January 9, 2019	10:00 am - 11:00 am
Modified Stage 2 for New Meaningful Users	January 14, 2019	12:00 pm - 1:00 pm
Meaningful Use Stage 3	December 20, 2018 January 24, 2019	11:00 am - 12:00 pm 10:00 am - 11:00 am
2018 MU Public Health Reporting	January 18, 2019	10:00 am -11:00 am
Security Risk Analysis (SRA)	January 22, 2019	2:00 pm - 3:00 pm

2017 MU Attestation Tutorial Series

NY Medicaid EHR Incentive Program has produced a series of MEIPASS tutorials to help you with your 2017 Modified Stage 2 or Stage 3 Meaningful Use Attestation

Part 1: Beginning the Attestation Process
https://www.youtube.com/watch?v=Wigjh2NY-Ic

Part 2A: Attesting to Modified Stage 2
https://www.youtube.com/watch?v=MhF3QUwV0qM

Part 2B: Attesting to Stage 3
https://www.youtube.com/watch?v=iDvdpZ-_qu4

Part 3: Clinical Quality Measure (CQM) Reporting
https://www.youtube.com/watch?v=z-SfnNgBI24

Part 4: eSignature and Attestation Submission
https://www.youtube.com/watch?v=cNkb6ZybeiE

Customer Satisfaction Survey

The NY Medicaid EHR Incentive Program is looking for feedback. We want to continue to provide quality services to Medicaid providers throughout New York State so we have developed and launched a new program survey. The survey is short (it takes less than 2 minutes to complete!) and we welcome your valuable insight. To complete the survey, visit: http://www.surveymonkey.com/r/ny_ehr.

Visit our Website

Find the following information and much more at https://www.health.ny.gov/ehr.

- Payment Year 2017 and 2018 Requirements – Modified Stage 2 and Stage 3
- 2017 Meaningful Use MEIPASS Tutorial Series
- Eligible Hospital Requirements
- Public Health Reporting Objective Information
- Post-Payment Audit Guidance
- Frequently Asked Questions (FAQs)
- Materials and Information – Document Repository
- Sign up to receive LISTSERV® messages - NY Medicaid EHR Incentive Program and Public Health

Questions? We have a dedicated support team ready to assist. **Contact us at 877-646-5410, option 2 or hit@health.ny.gov.**

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Medicaid Recipients with End Stage Renal Disease (New) Requirement to Apply for Medicare Benefits

To lower healthcare costs and provide additional medical benefits, the Department of Health recently began a new program to identify recipients with End Stage Renal Disease and tell them of their potential eligibility for Medicare benefits and the requirement to apply for Medicare. Consumers may reach out to their provider with questions about this notice. Many consumers are content with their Medicaid coverage and don't understand the difference between Medicaid and Medicare. The Department of Health is requesting provider assistance in directing consumers to the following website for further information about the Medicaid requirement to apply for Medicare. The Medicaid program has facilitated enrollers who can help consumers apply for Medicare benefits. More information can be found at: https://www.health.ny.gov/health_care/medicaid/esrd.

The Department thanks providers for their participation in this endeavor. If providers have any questions, they can contact the Bureau of Third Party Health Insurance, Office of Health Insurance Programs, at 518-473-5330.

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eMedNY Cycle Processing Calendar

A Claim Cycle is a weekly financial processing event in which NYS Medicaid claims are processed, checks and remittances are generated, and payments are sent out. Each Cycle has a unique sequential cycle number. Once claims have been accepted into the eMedNY system for adjudication, the date of acceptance can be used to look up the corresponding cycle number using the eMedNY Cycle Processing Calendar. Claims that were finalized at adjudication (not pended) will be reported in that cycle's remittance advice.

The Cycle Processing Calendar provides: the Claim Cycle Number; the Start Date and End Date of that week's cycle of adjudicated claims; the Check Date, which is the date the check is prepared; and the Check Release Date, the date in which payments are released. The Cycle Processing Calendar is a valuable reference tool and is available at: https://www.emedny.org/hipaa/news/PDFS/CYCLE_CALENDAR.pdf.

The example below shows the payment release date of 11/28/18 is for Cycle 2151 and is for claims adjudicated during the week of 11/01/18 – 11/07/18.

Cycle	Start Date	End Date	Check Date	Check Release Date
2151	11/01/2018	11/07/2018	11/12/2018	11/28/2018

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Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud or abuse complaints/allegations, call -877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website at https://www.emedny.org/.

Providers wishing to listen to the current week's check/EFT amounts:
Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
To sign up for a provider seminar in your area, please enroll online at https://www.emedny.org/training/index.aspx. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:
Call the Touchtone Telephone Verification System at (800) 997-1111.

Medicaid Prescriber Education Program:
For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog

http://nypep.nysdoh.suny.edu/home

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit https://www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record (EHR) Incentive Program questions?
Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication?
Please contact the editor, Georgia Wohnsen, at medicaidupdate@health.ny.gov